MISSOURI
DEPARTMENT OF MENTAL HEALTH

ANNUAL SAFETY REPORT

Submitted to Governor Matt Blunt
June 30, 2008

MATT BLUNT
GOVERNOR

KEITH SCHAFER, Ed.D.
DIRECTOR

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

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June 30, 2008

The Honorable Governor Matt Blunt
Lt. Governor Peter Kinder
The Missouri Mental Health Commission

Re: 2008 Annual Report on Implementation of Safety Recommendations

Dear Governor Blunt, Lt. Governor Kinder and Commissioners:

The Department of Mental Health (DMH) is pleased to present this Annual Report on this year's progress in implementing the safety recommendations of the Mental Health Task Force, chaired by Lt. Governor Kinder, and the associated recommendations of the Missouri Mental Health Commission.

If you review this document, you will see timely success in implementing a large majority of the recommendations, giving DMH significantly more tools in preventing and responding to DMH consumer abuse and neglect in our facilities and community programs. Our success is, in large part, due to the active and compassionate leadership of Governor Blunt and Lieutenant Governor Kinder, and of key legislative leaders such as Senator Michael Gibbons.

Most of the recommendations focused on systemic deficiencies reflecting an ineffective response to DMH abuse and neglect allegations as they occurred. Implementation of the recommendations also provides instructive data for future prevention strategies to deter abuse and neglect before it happens.

There are, however, major long-term system deficiencies not directly addressed by implementation of most of the recommendations. The two most notable problems are the inability of DMH and its community providers to retain key clinical staff and the ongoing training problems that creates.

DMH vacancy/turnover rates in many of critical clinical positions such as psychiatrists, psychologists, nursing staff, and direct care workers in any given month approaches 30%. The state and its community providers do not yet offer salary, benefits and training competitive to the open market for high-quality clinicians. Without them safety cannot ultimately be assured.

DMH is also experiencing patient over census (108-115%) in most of its state psychiatric facilities, in large part because of its inability to control admissions and discharges to the facilities, which are now almost wholly driven by court forensic procedures. As a result, we have become a crisis-driven system.

So, while we have made great progress on specific recommendations responding to the safety and credibility crisis in 2005-2006, the hardest work is yet to be done. We will continue to need the active interest and assistance of Missouri executive and legislative leaders to achieve the vision of safe and effective treatment and supports for Missourians in need of public mental health services.

Sincerely,

Keith Schafer, Ed. D.
Director

Contents

Executive Summary

The Annual Safety Report provides a status update of Department of Mental Health (DMH) activities and accomplishments in implementation of 25 recommendations made by the Governor-appointed Mental Health Task Force (MHTF), chaired by Lt. Governor Kinder. The final recommendation was that DMH prepare an annual safety report to be submitted to the Governor, Lt. Governor, and the Mental Health Commission (MHC) on June 30 each year. Since the first report was submitted in 2007, significant strides have been made to advance the recommendations. The 2008 report documents the following:

- Fifteen of the MHTF recommendations have now been completed.
- Six additional items are nearing completion.

FY 2009 Budget Appropriations Supporting Safety

The DMH budget for FY 2009 includes funding recommended by Governor Blunt and supported by the legislature for:

- Direct Care Staff Training (MHTF recommendation #4); and
- Direct Care Salary Enhancements (MHTF recommendation #8).

Institutionalizing Legislative Reform

Mental Health Reform legislation passed in 2007 provided authority for much of the change envisioned by the MHTF and the MHC. When Senate Bill 3 became statute on August 28, 2007, it allowed a great deal of forward movement for the safety recommendations included in the MHTF report. The foundation provided by the reform legislation allowed completion or advancement on the following recommendations:

MHTF Recommendation Number	SB 3 Provision	Status
2	Formal ties with state departments of Health and Senior Services' and Social Services' abuse reporting hotlines	 *
6	Fines & penalties for failure to implement plans of correction	
7	Fines & penalties for failure to report abuse or neglect	
13	Background checks and pending investigations	
14	Civil immunity for discussion of safety-related job performance	
15	DMH Fatality Review Board	
16	Public access to non-confidential final DMH investigation reports substantiating abuse/neglect	
23	Pursue legislation similar to elder abuse statutes	

** See Key on Page 8*

Those items presently incomplete will require development and promulgation of administrative rules which is underway.

Implementation Priorities: High Value Outcomes

In 2007, the Mental Health Commission worked with the DMH Executive Team to establish high priority items for implementation. The analysis included assignment of recommendations to categories based on both feasibility and value of the outcome expected if the recommendation were successfully implemented. The process established six priorities. Progress status for each is summarized below.

MHTF Recommendation Number	Focus Area	Status
2	Formal agreements with DHSS And DSS hotlines	* 2008
3	Standardized training for DMH consumers and families on identifying and reporting abuse and neglect	
9	Effectively track critical data on abuse, neglect and other safety information	2008
15	DMH Fatality Review Board	
17	Improved triage and prioritization of investigations	2007
25	Annual Safety Report	2007 & 2008

** See Key on Page 8*

Data Analytics for Safety

The Mental Health Commission, in collaboration with the Department's Executive Team, has established safety-related performance indicators for tracking and accountability. Beginning in 2008, quarterly performance indicator reports will be prepared for submission to the MHC and the DMH Executive Team. Public discussion in open MHC meetings promotes transparency and accountability for safety outcomes as well as improved communication with stakeholders.

Mental Health Commission Report Recommendations (MHTF #21)

As MHTF recommendation #21, the MHTF recommended that DMH pursue implementation of the Mental Health Commission (MHC) recommendations made in its August 2006 report titled "Building a Safer Mental Health System." Twelve recommendations in the MHC report were not specifically addressed in the MHTF report. The four listed below were completed in 2007:

- Separation of investigations from the Office of General Counsel
- Policy Directive to state-operated facilities regarding night and weekend on-site monitoring
- DMH leadership responsibility and accountability for fiscal matters and prioritization when resources for services are reduced or impact quality
- Augmentation of DMH Executive Team

The remaining eight recommendations continue to receive attention. Although progress is being made, many require resource development and long-term strategic planning. These items include:

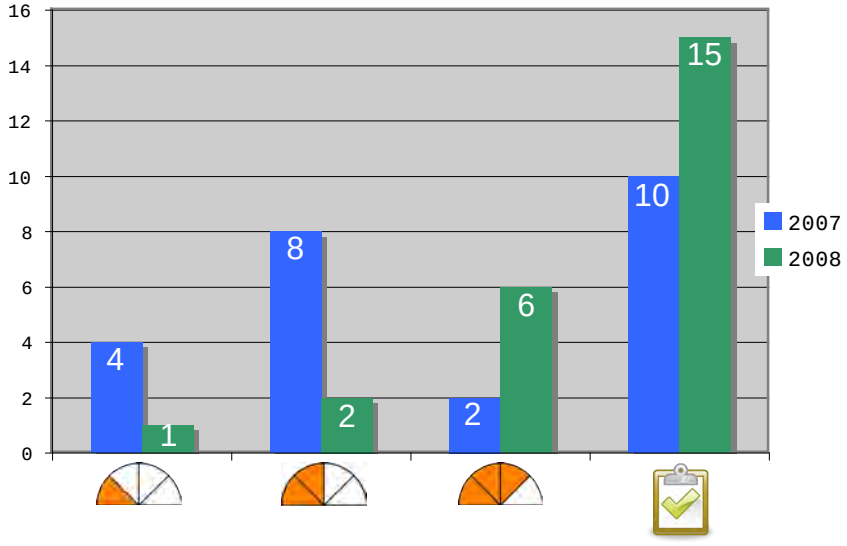
- Supervisory accountability
- Ombudsman programming
- Increased consumer and family voice*
- Flexible funding options*
- Video camera surveillance
- Drug and mental health courts*
- Increase Crisis Intervention Training for law enforcement*
- Comprehensive plan for mental health needs for Missouri's elders*

**Items above marked with an asterisk are being addressed as part of Transformation initiatives for mental health and mental retardation and developmental disabilities that are supported by federal funds.*

Overview of Safety-related Progress from 2007 to 2008

In summary, continued and dedicated safety-related activities are underway and have resulted in significant demonstrable progress, as summarized below.

- Ten MHTF recommendations were completed in 2007.
- An additional five recommendations were completed in 2008 (including the annual report required by recommendation #25).
- The status of Recommendation #21 (which is a series of recommendations made by the MHC) remains "in progress," with four items completed and five of the eight remaining recommendations showing additional progress in 2008.
- Of the remaining nine MHTF recommendations, additional progress was made for seven recommendations in 2008.



Introduction

Purpose of Report

As the final recommendation in its November 2006 report to Governor Matt Blunt, the Mental Health Task Force (MHTF) mandated the creation of an annual safety report to be prepared by the Missouri Department of Mental Health (DMH). The annual report, due each year starting June 30, 2007, is to be submitted to:

- The Governor;
- The Lt. Governor; and
- The Mental Health Commission (MHC).

Its purpose is to summarize DMH progress in implementing twenty-five (25) safety-related recommendations made by the Mental Health Task Force in 2006 that were developed after a groundbreaking and exhaustive review and analysis of policies, practice, and operations affecting the safety of DMH consumers. The information contained in this document has been compiled to satisfy the annual report requirement for FY 2008 by summarizing DMH efforts to improve safety for all DMH consumers.

"It is the fundamental responsibility of government to protect its most vulnerable citizens. The task force recommendations are an important tool to help fulfil that responsibility and ensure Missourians receiving mental health service are not at risk of abuse or neglect."

- Governor Matt Blunt

Background Information

At A Glance:

- *Governor orders change*
- *MHC issues recommendations*
- *MHTF report issued 11/06*
- *Governor issues 12/06 executive order*
- *Mental Health Reform Bill*

In 2006, Governor Blunt responded swiftly to public concern about safety for DMH consumers. He immediately issued a set of directives designed to increase DMH accountability and made available the resources and assistance of other state agencies to address the pressing safety matters. In addition, Governor Blunt appointed a Mental Health Task Force (MHTF), designating Lt. Governor Peter Kinder as the chair and Dr. Ron Dittemore, the interim DMH director at the time, as co-chair. Lt. Governor Kinder convened the Mental Health Task Force to review best practices and make recommendations for changes to the mental health system that would result in improved safety for DMH consumers. The series of meetings included public testimony at six locations across the state where nearly 300 Missouri citizens stepped forward to make their voices heard. After months of public dialogue and careful deliberation, the MHTF issued its report in November 2006.

The Mental Health Commission responded as well, undertaking a systematic study to identify methods to enhance consumer safety. The Commission's efforts resulted in an August 2006 report that outlined a set of recommendations for strategic actions to improve short-term and long-term safety outcomes for DMH consumers and increase transparency and accountability by DMH leadership.

As the President Pro Tem of the Senate, Senator Michael Gibbons sponsored safety-related legislation in the 2007 session, known as "the mental health reform bill." The bill outlined a series of important measures, based on the work of the MHTF, designed to ensure safety for those participating in the services provided or purchased by DMH. The legislation was successfully passed on May 18, 2007, and became law on August 28, 2007.

Key provisions of the legislation address:

- Expanded availability of final reports of substantiated Department of Mental Health abuse and neglect investigations issued on or after August 28, 2007, with some restrictions to protect identifying information
- Increased penalties for a mandated reporter who fails to report abuse and neglect
- Established financial penalties for community providers who do not correct problems cited in DMH licensing inspections
- Created a mental health fatality review panel to review all suspicious deaths of clients of the Department of Mental Health

Interested readers can learn more about the bill in its final form at:
http://www.senate.mo.gov/07info/BTS_Web/Bill.aspx?SessionType=R&BillID=162

These statutory changes provide the foundation for much of the progress presented in the 2008 report as DMH operationalizes and institutionalizes the statutory requirements.

As recommended by the MHTF, the first Annual DMH Safety Report was submitted on July 1, 2007. The report was broadly disseminated and is posted on the DMH website at www.dmh.mo.gov/spectopics/DMHSafetyReports.htm. In addition, the executive summary and summary charts from the report provided a distilled version for distribution and discussion with interested stakeholders.

The 2008 report will be shared in a similar manner and also will be available at www.dmh.mo.gov/spectopics/DMHSafetyReports.htm for public review.

FY 2009 Budget Appropriations Supporting Safety

The Department of Mental Health developed a number of FY '09 budget items to implement MHTF recommendations listed below.

- MRDD Risk Reduction item for $500,000
- Training Investments for Safety and Quality for $3,091,092
- Direct Care Staff Career Pathway for $3,331,297
- Increasing direct care entry level salaries by eliminating trainee class for $320,644

- Hazard pay differential for direct care in maximum security settings for $373,176

Governor Blunt included in his budget recommendations a 3% COLA for all DMH employees and a recruitment and retention item for security aides as well as a number of items included in the DMH request. Unfortunately, with evolving economic forecasts and a changing revenue picture, the Legislature approved a more conservative appropriations package for DMH and other state agencies. DMH did not receive the full request for training nor did it approve a hazard differential for direct-care staff in maximum security or the proposed direct care career pathway. Specifically, the DMH FY 2009 budget includes funding for:

Safety-Related Decision Item	Appropriation Amount
3% COLA for all employees, totalling $8.5 The amount shown benefits direct-care staff.	$3,520,621
Recruitment and retention item for security aides	$332,189
Training Investments for Safety and Quality, including training to certify direct care staff in facilities and community as well as training for supervisors	$1,000,000
Personnel Advisory Board approved repositioning to eliminate client attendant trainees and increase entry level pay for direct care staff during first six months of employment	$320,645
MRDD Health Care Risk Reduction Project was incorporated as part of the MH Partnership Technology item	$500,000
TOTAL	***$5,673,455***

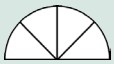
These appropriations are directly related to critically important recommendations in the MHTF plan. The funds will provide important resources to support action steps and infrastructure development for DMH consumer safety.

Implementation Progress for MHTF Recommendations

Overview of Strategic Progress

The 2008 report reflects the greatest progress for those recommendations that were institutionalized as statute by Senate Bill 3 (SB 3). The comprehensive summary table of progress on page 9 provides an at-a-glance view of the current implementation status for all MHTF recommendations. The table is followed by an item-by-item narrative for each recommendation that describes significant progress updates for FY 2008. Each recommendation is formatted to include a chart that states the full recommendation, any corresponding sources for the recommendation, a dot-point action summary, and a gauge icon to represent progress toward completion. A more detailed review of accomplishments is included in the narrative following each chart. The key below is helpful to interpret the charts that accompany each recommendation.

Progress Key



Implementation scheduled

Initial implementation underway

Implementation is well underway

Final implementation phase and nearing completion

Recommendation completed

MHTF	Mental Health Task Force
MHC	Mental Health Commission
GEO	Governor's Executive Order

Comprehensive listings of the recommendations made by both the MHTF and the MHC are included as Appendix A and Appendix B of this report. For readers interested in further specifics, the full text of both reports is available online at the following web locations.

Report	***Web Address***
MHTF report	http://www.dmh.missouri.gov/mmhtaskforce/index.htm
Mental Health Commission	http://www.dmh.missouri.gov/spectopics/MHCreport.pdf

Number	Recommendation	2008 Status
1.	National accreditation of MRDD habilitation centers and contracted community providers	
2.	Formal ties with DHSS Adult Abuse & DSS Child Abuse hotlines	
3.	Standard individualized training for consumers and families on identifying and reporting abuse and neglect	
4.	Standardized training for all DMH and provider staff on identifying and reporting abuse and neglect	
5.	Redesign DMH process for licensure and review of community-based providers within the next 12 months	
6.	Pursue legislation and amend regulations for administrative actions, up to and including fines, for failure to implement plans of correction	
7.	Fines or other penalties against licensed, certified, or contracted entities for failure to report abuse and neglect	
8.	Salary enhancement for direct care staff	
9.	Effectively track critical data on abuse, neglect, and other safety information	
10.	Use of Root Cause Analysis (RCA) for complaints and issues which are recurring	
11.	Commitment to providing public and community based services that afford real choices for all Missourians who require DMH services	
12.	Review policies and procedures to ensure that consumer health, safety, and welfare are the first and foremost priorities of DMH staff	
13.	Background checks on all potential employees to determine whether the individual is the subject of a pending investigation	
14.	Civil immunity to providers and DMH administrators allowing open discussion of individual job performance, etc.	
15.	DMH Fatality Review Board	
16.	Allow public access to non-confidential information in final reports of substantiated abuse and neglect, etc.	
17.	Triage of incidents for joint investigation of all deaths or near deaths that are suspect for abuse or neglect, etc.	
18.	Incidents not impacting consumer safety as defined and enforced by Department policy are handled administratively through disciplinary procedures	
19.	Enhance DMH investigations process by evaluating recommendations from sister agencies on this Task Force and implementing all that are feasible	
20.	Determine appropriate DMH investigation workload	
21.	Implement MHC report recommendations to fullest extent possible	**In progress**
22.	Review and revise DMH Memorandum of Understanding (MOU) with Missouri Protection & Advocacy Services	
23.	Pursue legislation similar to elder abuse statutes	
24.	Public/private partnerships for MRDD services	
25.	Annual safety report to the Governor, the Lieutenant Governor, and the Mental Health Commission on implementation progress	

Recommendation # 1:
Accreditation of MRDD Facilities and Programs

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue survey readiness towards national accreditation of its six habilitation centers and contracted community providers serving persons with developmental disabilities.	✔	✔	

Action to Date	Status
Habilitation Centers • Training by the Council for Accreditation of Rehabilitation Facilities (CARF) provided for leadership staff at Habilitation Centers was completed July 2007. • Consultation regarding CARF requirements and process for accreditation completed January 2008. • CARF conducted readiness surveys at habilitation centers. ***Community Providers*** • Informational meetings held in Spring 2007 by CARF and Council on Quality Leadership (CQL) representatives in four locations • Human Services Research Institute (HSRI) surveyed all other states to determine promising practices for state DD authority use of accreditation to promote safety and quality in service delivery. • Draft report of survey results developed by HSRI and submitted to Division • Report finalized and accepted by the Division	

Accomplishments: The use of accreditation by nationally recognized, third-party reviewers as a tool to improve safety, service quality, and accountability has been embraced by MRDD stakeholders. The Division has established as goals for the accreditation effort that:

- all habilitation centers will be accredited; and
- increasing numbers of community providers will be accredited.

Toward these ends, the Division has been working diligently with both the Council on Quality Leadership (CQL) and the Commission on Accreditation for Rehabilitation Facilities (CARF). The habilitation centers are actively working to identify policy, procedure and practice necessary to prepare for CARF survey. The first habilitation center survey with CARF is targeted for May 2009.

The Division has contracted with HSRI to develop a report that will serve as the basis for an MRDD accreditation model for MRDD community provider agencies and includes recommendations and strategies for successful completion. The final report was resubmitted and recently accepted by the Division.

The implementation arc for this recommendation extends several years in order for DMH facilities and community provider agencies to build infrastructure to meet certification standards, conduct necessary pre-survey activities, and apply and schedule on-site review.

Recommendation # 2: Formal Ties with Hotlines

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall work with the Department of Health and Senior Services to establish formal ties to its adult abuse hotline, and with the Department of Social Services for formal ties to its child abuse hotline, so that reporters of abuse and neglect of DMH consumers fully utilize those hotlines as another means of reporting abuse and neglect. The Department shall then rigorously promote the use of these hotlines.	✔		✔

Action to Date	Status
• Joint meetings with DHSS between July and December 2007 culminated in a written memorandum of understanding (MOU) signed in January 2008 • Using framework of draft DHSS MOU, a joint agreement was established with DSS in September 2007 • Contact people established at all agencies for troubleshooting any problems or implementation issues • With agreements in place, periodic meetings will be scheduled to assure effective "handoff" between the hotlines • MOUs will be reviewed periodically and revised as necessary	

Accomplishments: A series of meetings resulted in an agreement between DHSS and DMH to establish a process for effective relay of calls from the DHSS Adult Abuse hotline to DMH for reports of abuse and neglect in DMH facilities or providers. The agreement addresses effective handoff, including electronic 24/7 referrals, data collection, and quality review. The written agreement was signed by both department directors in January 2008. DHSS requires annual renewal for all MOUs; therefore, the document will be executed each year including any necessary revisions.

Using a similar process and draft agreement, DMH met with DSS to establish agreements for referral of child abuse hotline calls that are related to abuse and neglect of DMH consumers or in DMH facilities. The DSS MOU was completed and signed in September 2007.

Recommendation # 3: Training for Consumers and Families

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health facilities and community providers shall develop standard individualized training for consumers and families on identifying and reporting abuse and neglect, including their responsibilities as permissive reporters.	✔		✔

Action to Date	Status
The Office of Consumer Safety (OCS), in conjunction with the program Divisions, completed a safety brochure to distribute to consumers. • Completed brochure development in February 2008 • Printed brochure In March 2008 • Disseminated brochure to facilities • Collaborating with community providers to adapt brochure to community settings Supporting a variety of training efforts in DMH facilities and in the community to educate consumers and families about safety and reporting of abuse neglect including new provisions of SB 3	

Accomplishments: Information and empowerment of consumers/families is regarded as an effective and powerful prevention tool related to abuse and neglect. The first step was the development of a brochure that will be widely disseminated and used as a tool to educate consumers and families about abuse and neglect and how to protect themselves and their family members from harm. The brochure addresses:

- Identification of abuse/neglect
- Reporting
- Self-advocacy
- Prevention from harm.

The brochure was completed in February 2008 and will be adapted to provide examples that will assist consumers and families to identify warning signs in different service settings that should be reported. The brochure will be disseminated to consumers and their families upon admission to a facility or program, when moved to a more restrictive setting or upon request. Many programs will require staff to review the brochure with consumers and provide explanations and assistance as necessary.

A video that mirrors the brochure is in final stages of production and will also be available as a tool for programs. The video will also be posted on the Network of Care site for download and review.

In addition, the OCS is leading efforts with the Divisions to develop and support tailored training sessions to educate consumers and families about abuse and neglect and inform them about self advocacy. Each Division is identifying training strategies appropriate to their constituencies. Strategies will include use of a variety of media including distribution of written information, web posting, and online and live training events. An important principle for the work group will be the strategic delivery of information at critical times in an individual's treatment such as first time admission to a DMH facility or program, transfer to a more restrictive level of care, changes in residential facilities, or when treatment plans are modified or a behavior support plan is created. To increase the effectiveness of this strategy, DMH will explore use of consumers and families as trainers, modeling after already existing promising practices such as People First of Missouri, Self-Advocates Becoming Empowered (SABE), or Partners in Policymaking. Establishing partnerships with key advocacy groups such as National Alliance on Mental Illness (NAMI), People First, the Developmental Disabilities (DD) Council, Missouri Protection and Advocacy (MO P & A), and others will be another important strategy for intensifying training impact as well as extending resources for delivery of the information. A national training and education model titled Stop the Violence is being piloted in CPS facilities as a possible curriculum for use throughout the psychiatric system.

Recommendation # 4: Standardized Training

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall amend its Departmental Operating Regulations (DORs) and administrative rules to require standardized training based on best practices for all DMH and provider staff on identifying and reporting abuse and neglect. Law enforcement expertise should be utilized in the development of such training. The Department of Mental Health shall also standardize training protocol for investigators that includes review of policies and procedures, supervision levels, and training on the Safety First manual. The Department shall implement a mentoring program for new investigators that will include teaming them with seasoned investigators.	✔		✔

Action to Date	Status
• DMH Human Resources (HR) managed an implementation work group to: o Develop training content for the DMH e-learning catalogue, including responsibilities for reporting abuse and neglect o Implement a comprehensive e-learning orientation and basic training for direct care staff in DMH facilities o Produce and edit elearning modules to operationalize training o Trained administrators for establishing infrastructure of training tracking program to feed SAM II system o Broad-based implementation in final implementation stages o Continued development work expected over next several years using the FY 08 Safety Training appropriation • Investigations Unit (IU) director and supervisors revised and updated Investigation Unit manual to reflect current and best practice • MRDD conducted review of 2002 Safety First initiative to identify needed revisions and updates	

Accomplishments:

Under the leadership of HR, a Departmentwide committee was established to develop a catalogue of training resources to be delivered electronically through the eLearning component of the DMH-supported Network of Care. Using the 2008 safety appropriation, the committee has been working with the Missouri Institute for Mental Health (MIMH) to develop standardized modules for direct care staff across DMH related to safety, standardized procedures and basic skills and competencies for working with DMH consumers. These training modules will serve as the foundation for training direct care staff and will be supplemented by face to face training and supervision to support and sustain skill acquisition by the direct care workforce. Critical modules will address abuse and neglect reporting and response protocols as an important part of the eLearning catalogue. Much work has been done on the catalogue development.

Eleven modules are complete with more under development. Four facilities are in test phase. Additional development will be necessary to complete basic orientation and skills catalogue for DMH direct care staff. The catalogue will require ongoing updates and revisions to keep it current and complete. In order to more effectively manage this important work effort, DMH requested as part of its budget request to redirect an FTE to coordinate DMH safety training and manage the appropriated resources. Unfortunately, the legislature did not support that portion of the budget request.

In implementing an electronic learning strategy, the Department faces a number of challenges that will require ongoing attention and long-term planning to address. Key among them are technological and equipment issues such as sufficiency of bandwidth to support effective media use in training modules, access to computer work stations on or adjacent to resident living space to allow access to training modules, and tracking of training to assure that direct care staff have received and successfully mastered the content of training provided.

An important functional tool of the eLearning program is the capability to electronically track and document training assignment and completion. Substantial work has been required to establish a tracking system that will crosswalk to the OA SAM system that houses a training database for state employees. This functionality is necessary to enable ease of reporting so supervisors can easily track and manage training-related requirements for their supervisees. A total 5,192 eLearning training accounts are in place meaning that these DMH employees have access to use the eLearning system.

Additional training funding of over $3 million was requested by DMH for FY 09 and the Governor supported $2 million in his recommended budget to expand training to address community based services. The Legislature authorized DMH to spend $1 million in federal earnings for training but no new General Revenue was appropriated and the FTE requested was not included in the FY 09 budget. In addition, a 3% core reduction applied to all FY 08 E&E will result in a reduction of the FY 08 Safety Training appropriation beginning in FY 09.

The purpose of the MRDD “Safety First” initiative was to address risk management issues in Missouri Habilitation Centers when it was developed in 2002. Indicators included in Safety First efforts related to staff training, risk assessment, levels of supervision, rights, and monitoring of consumers. The indicators are tracked and trended to identify opportunities for improvement. In order to align Safety First with current risk management and quality assurance practices, MRDD conducted a formal review to gather feedback about suggested additional methods for better integrating Safety First and quality assurance. The resulting approach is that MRDD will compare Safety First with RISK systems to develop a comprehensive integrated Quality Improvement (QI) system.

Recommendation # 5:
Redesign of DMH Licensure and Certification

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall redesign its process for licensure and review of community-based providers within the next 12 months. The process should include a review of best practices from other states. Annual site visits to facilities should be mandatory. Part of this process should include routine communication between the Investigative Unit and the Division of MRDD so that facilities with increased numbers of allegations can be targeted for additional assistance in maintaining consumer safety.	✔		

Action to Date	Status
MRDD has undertaken a process to conduct annual review of rights, health and safety issues with community providers. • After review of best practices in other states, a tool for on-site review was developed and is posted on the MRDD website • Testing has been implemented via a pilot from December 2007 to March 2008 • Pilot information being compiled into report format • Communications protocols between Investigative Unit and Licensure and Certification are in place	

Accomplishments: Current updates about MRDD efforts are available on the DMH website and the draft tool for Essential Safeguard Systems Review (ESSR) is available at www.dmh.mo.gov/mrdd/provider/hcbswaivercertificationrevisions for review.

Recommendation # 6:
Penalities for Failure to Implement Plans of Correction

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation and amend regulations involving Licensure & Certification to permit administrative actions, up to and including fines, for failure to implement plans of correction.	✔		

Action to Date	Status
• Authorizing statutory language for this recommendation enacted August 28, 2007, as part of SB 3 • DMH will develop rules to collect fines when a comprehensive rule is completed related to the Department's certification model referenced in Recommendation 5 above	

Accomplishments: This provision was included in SB 3, the "mental health reform bill" that became law on August 28, 2007. This act increased the penalty for community providers who fail to correct problems cited by the Department of Mental Health in licensing inspections. The current fine of $100 per day was increased to as much as $10,000 per day. Similar penalties have been implemented in other states to promote compliance with regulatory provisions that enhance consumer safety. In order to implement this provision, rule changes to DMH licensure and certification will be needed. Amendments to the rules will be addressed as part of the comprehensive review of licensure and certification required in Recommendation #5.

Recommendation # 7:
Penalities for Failure to Report Abuse and Neglect

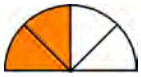
Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation and amend regulations that permit fines or other penalties against licensed, certified, or contracted entities for failure to report abuse and neglect, based upon organizational misconduct.	✔		

Action to Date	Status
• Authorizing statutory language for this recommendation enacted August 28, 2007 as part of SB 3 • Plan in place to create the authority through administrative rules for licensure and certification to penalize providers who are in violation of this provision	

Accomplishments: This provision in SB 3, the "mental health reform bill," increases the penalty from an infraction to a Class A misdemeanor for a mandated reporter failing to report abuse and neglect. This act also imposes sanctions and penalties on providers that prevent or discourage the reporting of abuse and neglect. Penalties similar to this in other states are regarded as effective prevention. Amendments to DMH regulations will be required to establish methodology for implementation. Although the 2007 report indicates that revisions to DMH contracts would be pursued, DMH has now determined that a contract amendment is not the appropriate method for implementation and that an administrative rule is the appropriate implementation strategy.

Recommendation # 8: Enhance Direct-Care Salaries

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health must improve the quality of care by enhancing the salaries of direct care staff to be commensurate with the level of skill and responsibility required of those positions in both state operated and community based care.	✔		

Action to Date	Status
• With Governor's support, the 95th General Assembly granted: o a 3% COLA for all state employees, resulting in an additional $3,520,621 appropriation for direct-care classes o an appropriation of $332,189 for an additional one-step increase for direct-care staff in high-security settings • DMH presented to the June 2008 Personnel Advisory Board (PAB) advocating for additional direct-care salary increases as part of their pay plan for FY 10 • DMH will explore alternative budget strategies to improve salaries for direct-care staff in the community and in state-operated programs and facilities	

Accomplishments: Reducing staff turnover, recruiting appropriate staff and communicating high expectations require adequate salaries commensurate with the skills, training, responsibilities and risks required for direct care staff. In addition to repositioning strategies to increase compensation for direct care staff and COLA advancements to keep up with ever-increasing costs for fuel and food, DMH proposed the development of a career ladder for direct care allowing certified staff to be paid more and to motivate interest in training and quality. Unfortunately, the new decision item did not receive support for FY 09 although it did generate a lot of interest and discussion.

DMH submitted written testimony to the June, 2008 Personnel Advisory Board meeting in support of additional salary advancements for direct care staff as part of its pay plan for FY 10. DMH will explore other strategies and new decision items in the FY 10 budget to enhance direct care compensation and benefits. However, with bleak economic projections, the 2010 environment may not be conducive to passage.

Recommendation # 9: Data and Quality Improvement

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health must implement an information management system that can rapidly and effectively track critical data on abuse, neglect, and other safety information. This data will be used as a component of the Department's continuous quality improvement plan and the Department's annual report to the Governor and Lieutenant Governor. Additionally, information technology should be developed to integrate all state departments' data for tracking any facility related inspections, complaints, investigations, etc. for both public and community based care.		✔	✔

Action to Date	Status
• Events Management and Tracking (EMT) fully implemented. Future system enhancements to be managed through DMH IT steering committee • The DMH Executive team in collaboration with the MHC identified consumer safety indicators for use in performance tracking and presented to MHC in December 2007 • Data collection and analysis protocols developed and finalized. • First quarter data provided to MHC at May, 2008 meeting with summaries to be published and presented quarterly	

Accomplishments: The EMT system was fully implemented and is available to generate individual and aggregate data related to abuse and neglect as well as deaths and other critical safety-related incidents. The IT steering committee will be responsible for any system enhancements needed to effectively manage and track information.

Consistent with Dr. Schafer's commitment to data analytics, a data analytics proposal was presented to the December 2007 MHC meeting, identifying a series of performance indicators for tracking. After input and feedback, an agreement was reached on the items to be tracked and routine reporting protocols to DMH leadership and to the MHC.

Thereafter, Division staff under the leadership of the Office of Transformation established protocols and agreements to assure comparability of reporting on similar items and to establish consistent reporting formats. The first quarterly report of fifty-seven (57) performance indicators was presented to the MHC at its May 2008 meeting. The following summary chart provides an overview of the indicators, some of which include further breakouts by consumer's age and facility type.

Division	ADA	CPS	MRDD
Number of Indicators	**12**	**29**	**16**
Safety-Related Indicators	• Deaths • Abuse and Neglect (A/N) Reports by type & substantiation rates • Treatment Retention	• Client deaths & injuries • A/N Reports by type & substantiation rates • Client involvement with legal system • Staff vacancies & turnover • Psychiatric bed diversion • Medication errors • Unsuccessful discharges • Restraints & seclusion • Staff Injury	• Client deaths & injuries • A/N Reports by type & substantiation rates • Readmissions to habilitation centers • Staff vacancies • Medication errors • Restraints • Staff Injury • Behavior Support Plans

In addition to quarterly reporting of performance indicators, the Investigations Unit, the Divisions, and facilities have the ability to run reports and apply quality management strategies to make safety-related improvements in service delivery. As an example, Fulton State Hospital has had a dedicated and successful program to identify risk prediction factors associated with restraint and seclusion and as they are able to reduce utilization, there is reduced opportunity for consumer and staff injury. This and other programs have great utility in improving safety for DMH consumers.

DMH is also participating in the Missouri Center for Patient Safety Just Culture Collaborative, examining ways to increase incentives for reporting adverse events and strengthen the safety culture within the Department.

Recommendation # 10: Root Cause Analysis

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall review completed investigations and explore Root Cause Analysis (RCA) for complaints and issues which are recurring. Root Cause Analysis should include, but not be limited to: examination of supervision levels and staffing and identification of facility system failures for both public and community based care.	✔		

Action to Date	Status
• RCA continues to be used in JCAHO accredited CPS facilities for all JCAHO-reportable critical incidents • All divisions will use RCA as a component of the Division death review process for those deaths that meet established criteria • DMH has made a commitment to use RCA as a component in the DMH Fatality Review process under development	

Accomplishments: RCA utilization and training will be an integral part of the development of death review protocols for suspicious and unusual deaths that provide instructional opportunities to improve safety and enhance the service delivery system. This year has provided an extensive opportunity for each Division to establish internal review and analysis capabilities and protocols that will then provide the foundation and the information to interact with the Department's Fatality Review Board that is presently under development as reflected in Recommendation # 15.

Recommendation # 11: Real Choices and Range of Services

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall make a clear and unequivocal commitment to providing public and community-based services that afford real choices for all Missourians who require DMH services. Because it is recognized that various types of care are needed for different individuals, the Department shall provide services on a person by person basis.	✔	✔	
Action to Date	**Status**		
• Completed in FY 2007 • Sustaining efforts	2007		

Recommendation # 12: DMH Commitment to Safety

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall review its policies and procedures, and ensure that the health, safety, and welfare of all its consumers are the first and foremost priorities of all employees -- investigators as well as the clinical staff -- of the Department. The Department's complaint investigation procedures need to be evaluated for effectiveness (including the benefits of allowing unannounced investigations) and a system put into place whose primary role is to assist in the prevention of abuse and protection of consumers through the investigation of abuse, neglect and misuse of funds.	✔		
Action to Date	**Status**		
• Completed in FY 2007 • Sustaining efforts	2007		

Recommendation # 13: Additional Background Checks

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall amend its regulations to create a process to require providers to conduct background checks on all potential employees to determine whether the individual is the subject of a pending investigation or finalized abuse or neglect case involving disqualifying events and require the provider to take appropriate steps to provide consumer safety.	✔		

Action to Date	Status
• A reporting method to identify individual alleged perpetrators has been developed that allows Investigation Unit staff to inform determiners when other allegations are pending • Search capability in EMT to create a history file for tracking allegations against a single employee • Legal analysis concluded that this information cannot be disclosed since due process has not been afforded the individual and it is inconsistent with established legal precedent related to human resource practice	

Accomplishments: The intent of this recommendation was to ensure that individuals would not be able to leave one job under allegations of abuse and neglect and move to another. EMT was revised in 2007 to include the capability of tracking individual names associated with investigations that are in process and those that have resulted in a finding of substantiated. Legal and HR discussions in the last year, however, have led to the conclusion that the existence of an ongoing investigation or unproven allegations about persons reported for investigation of abuse and neglect cannot be disclosed prior to completion of all due process. Only after an investigation has been completed, a determination has been made and all due process has been exhausted, can information be released about individuals who have been determined to have committed abuse or neglect.

Recommendation # 14:
Civil Immunity for Employer Discussion of Performance

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation providing civil immunity to providers and DMH administrators allowing open discussion of individual job performance in order to make employment decisions that affect the safety of consumers. However, the legislation shall not protect reckless, misleading communication or intentional misstatements.	✔		
Action to Date	**Status**		
• Completed in FY 2007 • Sustaining efforts	 **2007**		

Recommendation # 15: Death Review Board

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall craft a legislative proposal comparable to that which created Child Fatality Review Boards within the Department of Social Services. It would establish review of all deaths of adults who are in the care and custody of the Department of Mental Health. The board should include the expertise of pathologists or medical examiners, law enforcement, prosecutors, and advocates, including Missouri Protection & Advocacy Services.	✔	✔	✔

Action to Date	Status
• Held a series of meetings with Divisions and Licensure & Certification staff to develop conceptual and operational model for Fatality Review • Divisions have strengthened their internal death review processes for consistency and to serve as a foundation for the Departmentwide Fatality Review Panel (FRP) • MRDD has used their quality improvement unit for death review and is working on administrative rules for implementation • CPS has built on JCAHO RCA and review processes for death review • ADA is establishing internal protocols and accountability for death review • Established expectation that DMH Medical Director and the Director's Office will be heavily involved in this critical function • Position to serve as full-time staff to the FRP filled effective May 1, 2008	

Accomplishments: An administrative rule will need to be filed to guide operations and protect the confidentiality of this critically important quality enhancement function for DMH. A draft is in internal circulation with plans for external circulation and comment. This rule is not eligible for emergency promulgation according to administrative rule authority and statute. Once filed, the rule process requires approximately nine months before it takes effect. Before the rule becomes effective, the FRP will be convened for orientation and training. Next steps include development of a work plan with timeframes that will include, among other tasks: identification of FRP member candidates; managing the proposed rule through submission, comment and revision; preparing FRP orientation and training materials; and, preparation and presentation of deaths to the FRP along with protocols for the review and format for confidential written reports.

Recommendation # 16: Public Access to Final Reports Substantiating Abuse and Neglect

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation to allow public access to non-confidential information in final reports of substantiated abuse and neglect.	✔	✔	
Action to Date	**Status**		
• Statutory requirement became effective August 28, 2007 • Substantiated reports are released in compliance with statutory requirement			

Accomplishments: Since August 28, 2007, when SB 3 became law, substantiated abuse/neglect written reports are available with statutory restrictions that protect identifying information about clients and staff. When such requests are made, Legal Services staff conducts review to assure compliance with the statutory requirements.

Recommendation # 17: Process Improvements for DMH Investigations Protocols

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall develop a process for triage of incidents for joint investigation of all deaths or near deaths that are suspect for abuse or neglect, as well as incidents of physical assault and sexual misconduct. In order to conduct "triage," strict procedural guidelines must be developed to allow for proper prioritizing of cases. This process should include notification of and cooperation with local law enforcement.	✔	✔	✔
Action to Date	**Status**		
• Completed in FY 2007 • Sustaining efforts	 **2007**		

Recommendation # 18: Administrative Disciplinary Procedures

Full Recommendation	Recommendation Report Source(s)		
The Department of Mental Health and providers must ensure that incidents not impacting consumer safety as defined and enforced by Department policy are handled administratively through disciplinary procedures— though still tracked in the Department's information systems and monitored by executive staff. This would allow investigators to improve consumer safety by dedicating themselves to harmful incidents of abuse or neglect.	MHTF	MHC	GEO
	✔		
Action to Date	**Status**		
• Completed in FY 2007 • Sustaining efforts	2007		

Recommendation # 19: Sister Agency Investigations Improvement Recommendations

Full Recommendation	Recommendation Report Source(s)		
The Department of Mental Health shall enhance its investigations process by evaluating recommendations from the sister agencies on this Task Force and implementing all that are feasible.	MHTF	MHC	GEO
	✔		✔
Action to Date	**Status**		
• Completed in FY 2007 • Sustaining efforts	2007		

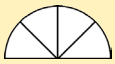
RECOMMENDATION # 20: DMH INVESTIGATION RESOURCES

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall evaluate the number of investigations completed by the Investigations Unit and determine the appropriate number of investigators needed in order to meet current mandated time frames, without sacrificing the quality of the investigation. Interviews shall be initiated within the first day of the investigation.	✔		
Action to Date	**Status**		
• Completed in FY 2007 • Sustaining efforts	 **2007**		

Recommendation # 21:
Implement Mental Health Commission Recommendations

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall work with the Mental Health Commission to implement the Commission's recommendations to the fullest extent possible.	✔		
Action to Date	**Status**		
• Efforts continue to implement recommendations as resources and authority allow.	In progress as noted in summary chart		

Accomplishments: Recommendation 21 by the Mental Health Task Force supported the recommendations from the Mental Health Commission contained in their report titled "*Building A Safer Mental Health System.*" Twelve recommendations in that report are not addressed in the MHTF findings. Progress toward implementation of these items is summarized in the chart that follows.

Mental Health Commission Recommendation	Action to Date	Status
DMH must separate investigations from legal counsel	The Investigative Unit was reassigned to the Deputy Director's office as a discrete and separate work unit effective March 1, 2007.	 2007
Increase expectations for Supervisors related to abuse & neglect reports	o Employee Misconduct initiative implemented o Elearning implementation is proceeding for DMH facilities o Just Culture Collaborative established with grant from Missouri Center for Patient Safety to explore value in CPS facilities o Failed FY 09 budget item to support supervisory training	
Make internal & external ombudsman available to consumers/families as well as phones for access	Options are being evaluated. Resource development necessary to implement.	
Explore options for family and natural supports in all aspects of DMH service delivery	MRDD Transformation and Mental Health Transformation efforts focus on efforts consumer access to family and natural supports when possible.	
Facility directors to be present during night/ weekend shifts at the facility	Sustaining	 2007

Mental Health Commission Recommendation	Action to Date	Status
When funding is inadequate to provide services, the scope of service must be reduced, all notified and decisions made by Director of DMH		2007
Support for flexible funding including the concept that "money follows the person" to maximize choices	Increased flexibility through MRDD Transformation initiative; DMH transformation initiative; DSS/DHSS/DMH money follows the person demonstration grant	
Augment the DMH Executive Team		2007
Consider video camera surveillance for all DMH facilities	Resource development required. Budget item for systemwide camera installation not supported for FY 09 budget cycle. Study project for new Fulton State Hospital Campus includes plan to include video surveillance throughout the property.	
Develop drug and mental health courts as diversion from incarceration	Divisions pursuing collaborative relationships with local entities, other Departments and with the Judicial system to develop interest and resources to support drug and mental health courts.	
Expand Crisis Intervention Training (CIT) to prevent inappropriate incarceration	$200,000 approved in FY 09 DMH budget.	
Develop a comprehensive plan to meet the mental health needs of aging DMH clients.	The Transformation Working Group (TWG) identified gaps in mental health services to older Missourians and requested greater attention to their needs in the next update of the state's Comprehensive Transformation Plan. A Mental Health and Aging Work Group was chartered by the TWG with the purpose of identifying and prioritizing problems facing older adults and creating specific action plans to address the needs. The work group recommendations are to be completed by January 2009.	

Recommendation # 22:
Update Agreement with Missouri Protection and Advocacy

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health's Memorandum of Understanding (MOU) with Missouri Protection & Advocacy Services (P&A) shall be reviewed and amended if necessary to clarify roles and expectations. The terms of the MOU shall be made broadly available and become part of orientation and annual training for employees, consumers, and families.	✔		✔

Action to Date	Status
• Held series of meetings in last year with DMH, P&A and DMH provider community providers as participants • Draft agreement disseminated broadly for comment in February 2008 • Final agreement sent to P&A in May 2008 • Once signed, joint training will be developed & jointly delivered	

Accomplishments: Agreement will be executed once signatures of both agencies are completed. DMH and MO P&A have agreed to develop and conduct joint training regarding the agreement and its requirements.

Recommendation # 23:
Pursue Legislation Similar to Elder Abuse

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation to amend Sections 565.180, RSMo, et. seq., which pertains to the crime of elder abuse, to incorporate the crime of patient, resident, or client abuse or neglect of a Department consumer currently provided for in Section 630.155, RSMo.	✔		

Action to Date	Status
• Completed in FY 2007 • Sustaining efforts	2007

Recommendation # 24:
Public/Private Partnerships for MRDD Case Management

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health, Division of Mental Retardation/Developmental Disabilities (MRDD), shall create a committee of key stakeholders to evaluate the feasibility of public-private partnerships to deliver case management services, determine eligibility, manage local wait lists, and provide and/or contract for a system of programs and services in their local areas.	✔	✔	✔

Action to Date	Status
• Committee completed its work in 2007 as required by recommendation • Implementation is well underway with 80 MRDD case managers transitioned in FY 08 and approval for an additional 100 in FY 09 and proposals for 80 more in FY 10	2007

Recommendation # 25: Annual Safety Report

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall prepare an annual report to the Governor, the Lieutenant Governor, and the Mental Health Commission on its progress in implementing these recommendations. It shall include data that indicates the level of safety in the mental health system, along with plans for additional action where needed. The first report shall be submitted on or before June 30, 2007.	✔		✔
Action to Date	**Status**		
• 2007 report submitted July 2, 2007 • 2008 report submitted June 30, 2008	 **2007**		

Accomplishments: The next report is due June 30, 2009.

Appendices

APPENDIX A: Mental Health Task Force Recommendations

Members of the Mental Health Task Force, Chaired by Lt. Governor Peter Kinder

Note: The recommendations that follow are from the report of the Mental Health Task Force. The full report, with recommendations and justification can be viewed at: http://www.dmh.missouri.gov/mmhtaskforce/index.htm

Recommendations

1. The Department of Mental Health shall pursue survey readiness towards **national accreditation** of its six habilitation centers and contracted community providers serving persons with developmental disabilities.

2. The Department of Mental Health shall work with the Department of Health and Senior Services to establish **formal ties to its adult abuse hotline**, and with the Department of Social Services for formal ties to its child abuse hotline, so that reporters of abuse and neglect of DMH consumers fully utilize those hotlines as another means of reporting abuse and neglect. The Department shall then rigorously promote the use of these hotlines.

3. The Department of Mental Health and community providers shall develop standard individualized **training for consumers and families** on identifying and reporting abuse and neglect, including their responsibilities as permissive reporters.

4. The Department of Mental Health shall amend its Departmental Operating Regulations (DORs) and administrative rules to require **standardized training** based on best practices for all DMH and provider staff on identifying and reporting abuse and neglect. Law enforcement expertise should be utilized in the development of such training. The Department of Mental Health shall also standardize training protocol for investigators that includes review of policies and procedures, supervision levels, and training on the Safety First manual. The Department shall implement a mentoring program for new investigators that will include teaming them with seasoned investigators.

5. The Department of Mental Health shall **redesign its process for licensure and review** of community-based providers within the next 12 months. The process should include a review of best practices from other states. Annual site visits to facilities should be mandatory. Part of this process should include routine communication between the Investigative Unit and the Division of MRDD so that facilities with increased numbers of allegations can be targeted for additional assistance in maintaining consumer safety.

6. The Department of Mental Health shall pursue legislation and amend regulations involving Licensure & Certification to permit **administrative actions**, up to and including fines, **for failure to implement plans of correction**.

7. The Department of Mental Health shall pursue legislation and amend regulations that permit **fines or other penalties** against licensed, certified, or contracted entities **for failure to report abuse and neglect**, based upon organizational misconduct.

8. The Department of Mental Health must improve the quality of care by **enhancing** the **salaries of direct care staff** to be commensurate with the level of skill and responsibility required of those positions in both state operated and community based care.

9. The Department of Mental Health must implement an information management system that can rapidly and effectively **track critical data** on abuse, neglect, and other safety information. This data will be used as a component of the Department's **continuous**

quality improvement plan and the Department's annual report to the Governor and Lieutenant Governor. Additionally, information technology should be developed to integrate all state departments' data for tracking any facility related inspections, complaints, investigations, etc. for both public and community based care.

10. The Department of Mental Health shall review completed investigations and explore **Root Cause Analysis** for complaints and issues which are recurring. Root Cause Analysis should include, but not be limited to: examination of supervision levels and staffing and identification of facility system failures for both public and community based care.

11. The Department of Mental Health shall make a clear and unequivocal commitment to providing public and community based services that **afford real choices** for all Missourians who require DMH services. Because it is recognized that various types of care are needed for different individuals, the Department shall provide services on a person by person basis. To that end, no habilitation center shall be closed as long as there is a need for its continued operation. Conversely, any habilitation center for which there is no need shall be closed.

12. The Department of Mental Health shall review Department policies and procedures, and ensure that the **health, safety, and welfare of all its consumers are the first and foremost priorities of all employees** -- Investigators as well as the clinical staff -- of the Department. The Department's complaint investigation procedures need to be evaluated for effectiveness (including the benefits of allowing unannounced investigations) and a system put into place whose primary role is to assist in the prevention of abuse and protection of consumers through the investigation of abuse, neglect and misuse of funds.

13. The Department of Mental Health shall amend its regulations to create a process to require providers to conduct **background checks** on all potential employees to determine whether the individual is the subject of a pending investigation or finalized abuse or neglect case involving disqualifying events and require the provider to take appropriate steps to provide consumer safety.

14. The Department of Mental Health shall pursue legislation providing **civil immunity** to providers and DMH administrators allowing open discussion of individual job performance in order to make employment decisions that affect the safety of consumers. However, the legislation shall not protect reckless, misleading communication or intentional misstatements.

15. The Department of Mental Health shall craft a legislative proposal comparable to that which created Child Fatality Review Boards within the Department of Social Services. It would establish **review of all deaths of adults who are in the care and custody of the Department of Mental Health**. The board should include the expertise of pathologists or medical examiners, law enforcement, prosecutors, and advocates, including Missouri Protection & Advocacy Services.

16. The Department of Mental Health shall pursue legislation to allow **public access to non-confidential information in final reports** of substantiated abuse and neglect.

17. The Department of Mental Health shall develop a process for **triage of incidents** for

joint investigation of all deaths or near deaths that are suspect for abuse or neglect, as well as incidents of physical assault and sexual misconduct. In order to conduct "triage," strict procedural guidelines must be developed to allow for proper prioritizing of cases. This process should include notification of and cooperation with local law enforcement.

18. The Department of Mental Health and providers must ensure that incidents not impacting consumer safety as defined and enforced by Department policy are handled administratively through **disciplinary procedures**— though still tracked in the Department's information systems and monitored by executive staff. This would allow investigators to improve consumer safety by dedicating themselves to harmful incidents of abuse or neglect.

19. The Department of Mental Health shall enhance its investigations process by evaluating **recommendations from the sister agencies** on this Task Force and implementing all that are feasible.

20. The Department of Mental Health shall evaluate the number of investigations completed by the Investigations Unit and determine the **appropriate number of investigators** needed in order to meet current mandated time frames, without sacrificing the quality of the investigation. Interviews shall be initiated within the first day of the investigation.

21. The Department of Mental Health shall work with the Mental Health Commission to **implement the Commission's recommendations to the fullest extent possible**.

22. The Department of Mental Health's **Memorandum of Understanding (MOU) with Missouri Protection & Advocacy Services** shall be reviewed and amended if necessary to clarify roles and expectations. The terms of the MOU shall be made broadly available and become part of orientation and annual training for employees, consumers, and families.

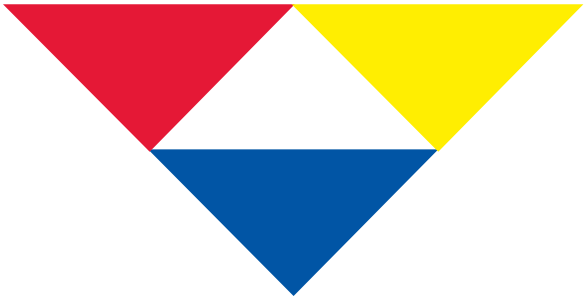
23. The Department of Mental Health shall **pursue legislation** to amend Sections 565.180, RSMo, et. seq., which pertains to the crime of elder abuse, to incorporate the crime of patient, resident, or client abuse or neglect of a Department consumer currently provided for in Section 630.155, RSMo.

24. The Department of Mental Health, Division of Mental Retardation/ Developmental Disabilities (MRDD), shall create a committee of key stakeholders to evaluate the feasibility of **public-private partnerships to deliver case management services**, determine eligibility, manage local wait lists, and provide and/or contract for a system of programs and services in their local areas.

25. The Department of Mental Health shall prepare an **annual report** to the Governor, the Lieutenant Governor, and the Mental Health Commission on its progress in implementing these recommendations. It shall include data that indicates the level of safety in the mental health system, along with plans for additional action where needed. The first report shall be submitted on or before June 30, 2007.

APPENDIX B: Mental Health Commission Recommendations

Missouri Mental Health Commission



Note: The recommendations that follow are from the report of the Mental Health Commission. The full report, with issues and recommendations can be viewed at: http://www.dmh.missouri.gov/spectopics/MHCreport.pdf

Recommendations

1. **Accreditation** of all habilitation centers should be pursued immediately. The level of accreditation should be commensurate with complex medical and mental health needs of persons that utilize these facilities. This includes provision and oversight for medical personnel and for training of staff to manage mentally ill patients. Similarly, an appropriate and feasible method for accrediting those community service providers who have not yet achieved accreditation must be pursued.

2. Information management methods must be implemented to rapidly and effectively **track critical data on abuse, neglect and safety** information. This means that all such data is organized in such a way that clusters of incidents are readily identifiable and reviewed by a member of the executive team. A dedicated information management staff should be appointed with responsibility to maintain surveillance over these events. If it is possible to dovetail this system with CIMOR (Consumer Information Management and Outcomes Reporting, the department's new management information system), it will be ideal since safety information and other indices of quality and utilization of care will allow for powerful resolution of weaknesses in the system. A critical aspect of the management of abuse, neglect and safety information must be to cross-refer data that is acquired in primary reporting systems with that acquired through back-up systems (see #4), to ensure integrity of the flow of control information.

3. There must be a proper **balance of investigative responsibility** that incorporates external resources (such as law enforcement, outside consultants, or other Missouri departments, etc.) to supplement internal investigation functions. Internal and external investigative functions in combination yield the best results maximizing the benefits of both. The primary responsibility for investigation of most serious incidents related to abuse, neglect or client safety should be placed with external review mechanisms to eliminate the appearance of a conflict of interest.

4. Every DMH facility and residential service provider must be held responsible for instituting and monitoring a fail-safe methodology for **timely reporting** of crucial incidents to Central Office. Such methods should include clear duality in the pathways through which this critical information flows. The submission of dual reports (one to facility leadership, the other to DMH Central Office), even if highly summarized (e.g., a mailed or electronically- submitted communication card), would allow for surveillance over the appropriate handling of such reports, and would protect against the information being dismissed or sequestered by administrators. All staff should be educated regarding the pathways of flow of the information. Thresholds for moving information to higher levels of authority must be clarified system-wide and specific protocols for reporting abuse and neglect information to the Mental Health Commission should be established.

5. The Department of Mental Health must **separate the internal authority for investigative procedures from its legal counsel**, in order to alleviate the inherent conflict of interest that is created when those who are charged with protecting the Department's legal interests are simultaneously charged with investigative authority.

6. The Department of Mental Health should aggressively support and facilitate the creation of **legislation to allow for non-confidential information regarding abuse and neglect to be made public**. The information should be analyzed and structured for ease of use by stakeholders, similar to formats used in public financial statements or annual reports. However, the department must be diligent in its analysis and presentation of the data to assure that it is fair, accurate, and respectful of the privacy of consumers and their families.

7. As a matter of policy, a fixed proportion of facility operating expenses should be set aside for the exclusive purpose of supporting continuing education and **training of staff**.

8. A system needs to be implemented by which supervisors are consistently held responsible for the actions of staff under their supervisory authority. **Supervisors must** also **be accountable** for information gathered by ombudsman related to the quality of service, their professionalism and the appropriateness of their human interactions with co-workers and clients.

9. Consumers, families and their advocates should have access to both an internal and external designated **ombudsman** whose responsibility is to independently collect complaints and reports of incidents, to preliminarily investigate those reports, and to provide summaries of its findings to both the executive team of the Department of Mental Health and to Missouri Protection and Advocacy. In addition, dedicated telephones should be readily available to consumers to allow unrestricted access for reporting to ombudsmen.

10. **All deaths** in DMH-funded facilities should be **reported to a coroner or medical examiner**. In addition, a dedicated DMH workgroup supervised by the executive team should review all deaths on a weekly basis and communicate any and all suspicious circumstances to the executive team.

11. The Department of Mental Health must explore multiple options for **external review** and involvement of family and natural supports in all aspects of service delivery. Facilitated by principles of open public disclosure and quality improvement, the department should provide meaningful venues for feedback and input.

12. The **relationship between regional centers and community service providers must be clarified**, and their work integrated to achieve efficiency and improve both accountability and quality of care. This will help address a problematic trend in which each presumes that control over programming lies with the other; the result of which is that effective leadership and decision-making are undermined.

13. Establish minimum requirements for facility directors to be present during night and weekend shifts in their respective facilities, as well as minimum requirements for **unannounced site visits** to all facilities.

14. Clear expectations must be maintained at all times about which incidents are reported to police, and surveillance of reporting to police (via cross-referencing of incident information and police reporting) must be maintained by DMH Central Office. A uniform **protocol for interface with law enforcement** must be established, based on legal precedent, and enforced.

15. The Department of Mental Health and the Governor must make a clear and unequivocal commitment to providing a **continuum of facility and community-based services that afford real choices** to all Missourians who require DMH services. The experiences of other state departments of mental health in the U.S. have demonstrated that there are clients with specific profiles of disability and or medical/psychiatric co-morbidity, who may be better served in dedicated centers than in community settings. Fear regarding loss of this option is a divisive element in undermining unified advocacy for severely- affected individuals served by DMH. Partnership with agencies that provide up-todate information to consumers and their families about quality residential services should be actively cultivated, and clients and their families should be assisted in the decision making process through a combination of individualized services: one-to-one mentoring, education regarding housing and provider resources, Medicaid training and advocacy, and support groups.

16. When funding is inadequate to provide service, the scope of service must be reduced, the public informed, and the **decisions about service reduction/prioritization should rest with the director of the department**. Such decisions should not be thrust upon the Regional Centers to "make do" with the money that is available.

17. The Mental Health Commission strongly supports **flexible funding options**, including the full implementation of Olmstead, which mandates that funding follow the consumer, allows their choice of support providers, including allowing families to care for their loved ones in their own homes utilizing natural supports.

18. The Department Director must **augment the executive team** in such a way that it improves inter-divisional communications, with adequate staffing to carry out the overarching mission of the Department of Mental Health.

19. **Video camera surveillance** should be strongly considered for all DMH facilities.

20. The Department should facilitate the development of **drug and mental health courts** which serve as a diversion from incarceration and have begun to successfully combine treatment with rehabilitation.

21. **Crisis Intervention Training** (CIT) should be further expanded in the state as a method to prevent persons with mental illness from being inappropriately placed in the criminal justice system. Police CIT teams can also prevent suicides and physical harm through intervention.

22. The Department must develop a comprehensive plan, including adequate staffing, for addressing the unique **mental health needs of aging DMH clients**.

23. The DMH **budget must stabilize**, recover (to compensate for relative losses suffered over the past decade), and be further supplemented to implement these recommendations. This will require legislative action. The "wait list" for MR/DD services, unavailability of appropriate inpatient and residential beds in the Division of Comprehensive Psychiatric Services (CPS), and inordinate delays in availability of treatment for ADA clients, represent a direct result of inadequacy of funding. In the interim, given the fact that these recommendations relate to abuse, neglect and safety, if it becomes apparent that adequate levels of funding are not available, we recommend a constriction of DMH services in order to direct funds to these critical efforts. The maintenance of safety must be an absolute priority in our system.

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